Patient Information

Patient's Name _____ Preferred Name _____ Sex ____
(First) (Middle) (Last)

Date of Birth _____ Age _____ Patient's Social Security No. _____

Home Address _____
(Street) (City) (State) (Zip)

Home Phone _____ Work Phone _____ Cell Phone _____

Marital Status _____ Email Address _____

Employer Name _____ Occupation _____

In the event of an emergency, please contact _____
(Name) (Phone number) (Relation)

Our practice utilizes a text message service for appointment reminders and confirmations; as well as two way texting with our patients. Please note standard text message rates contracted through your cellular phone provider may apply.

Responsible Party Information

Name _____ Relation _____ Date of Birth _____ SS# _____

Home Address _____
(Street) (City) (State) (Zip)

Home Phone _____ Work Phone _____ Cell Phone _____

Employer Name _____ Occupation _____

Dental Insurance Information

Dental Insurance Name _____ Subscriber No. _____ Group No. _____

Name of Primary Subscriber _____ DOB: _____ Do you have a secondary dental insurance: ☐ Y ☐ N

Please provide the front desk with your dental insurance card and inform us of any changes to your dental insurance including secondary policies.

Financial Policy

As a courtesy to the patient we verify, file and process your dental insurance and claims for you. If dental treatment is needed, we will estimate your portion (co-pay) to the best of our knowledge based on the information provided to us by you and your insurance company. Your copay and/or deductible are due, in full, the day of your appointment. We cannot guarantee your insurance will pay for any services based on eligibility as your insurance does not guarantee payment. Therefore, any balance not paid by insurance within 30 days will then become the patients' responsibility. The patient will be billed directly and the balance will be due immediately. Account balances must be paid in full in order to continue services with our practice. We accept credit card payment by phone using Discover, Visa or MasterCard and through our secure "Text to Pay" feature.

Cancellation Policy

If you are unable to keep your appointment, kindly give 24 hour notice. Failure to provide adequate notice of cancellation will result in a broken appointment. After three broken appointments, you may be dismissed from our practice.

HIPPA Authorization

Please provide the name of the person(s) authorized to call on your behalf and whom we are allowed to discuss your patient information with.

Name _____ DOB _____ Relation to self _____

Name _____ DOB _____ Relation to self _____

Print Name _____ **Signature** _____ **Date:** _____

PATIENT'S NAME: _____ DOB: _____

MEDICAL HISTORY: ***Do you currently have or have you ever had any of the following?***

☐ Y ☐ N Acid Reflux/GERD
☐ Y ☐ N ADD/ADHD
☐ Y ☐ N AIDS/HIV Positive
☐ Y ☐ N Allergies/Seasonal Allergies
☐ Y ☐ N Alzheimer's/Dementia
☐ Y ☐ N Anemia
☐ Y ☐ N Angina
☐ Y ☐ N Anxiety
☐ Y ☐ N Arthritis
☐ Y ☐ N Artificial Heart Valve
☐ Y ☐ N Artificial Joints or joint replacement
☐ Y ☐ N Asthma
☐ Y ☐ N Autism/Special Needs
☐ Y ☐ N Bleeding Disorder
☐ Y ☐ N Blood Pressure
If yes: ☐ High ☐ Low
☐ Y ☐ N Bipolar
☐ Y ☐ N Bronchitis
☐ Y ☐ N Cancer: Type _____
☐ Y ☐ N Cerebral Palsy
☐ Y ☐ N Chemotherapy/Radiation
☐ Y ☐ N Cold sores/fever blisters/ulcers
☐ Y ☐ N Congenital Heart Disorder
☐ Y ☐ N Cholesterol
If yes: ☐ High ☐ Low
☐ Y ☐ N COPD
☐ Y ☐ N Crohn's Disease
☐ Y ☐ N Current Shingles
☐ Y ☐ N Depression
☐ Y ☐ N Dementia
☐ Y ☐ N Diabetes: Type_____
☐ Y ☐ N Dialysis
☐ Y ☐ N Drug/Alcohol Abuse
☐ Y ☐ N Eating Disorder
☐ Y ☐ N Emphysema
☐ Y ☐ N Endometriosis
☐ Y ☐ N Epilepsy/Seizures
☐ Y ☐ N Esophageal Problems
☐ Y ☐ N Excessive Thirst
☐ Y ☐ N Fainting Spells/Dizziness
☐ Y ☐ N Frequent Cough
☐ Y ☐ N Gastro Intestinal Disease
☐ Y ☐ N Glaucoma
☐ Y ☐ N Gout
☐ Y ☐ N Handicap/Disabilities
☐ Y ☐ N Headaches/Migraines
☐ Y ☐ N Hearing Impairment
☐ Y ☐ N Heart Attack
☐ Y ☐ N Heart Disease/Failure
☐ Y ☐ N Heart Pacemaker
☐ Y ☐ N Heart Surgery
☐ Y ☐ N Hepatitis: Type _____
☐ Y ☐ N HPV (Human Papilloma Virus)
☐ Y ☐ N Immune Suppressive Disorder
☐ Y ☐ N Kidney Problems
☐ Y ☐ N Leukemia
☐ Y ☐ N Liver Disease
☐ Y ☐ N Lung Problems
☐ Y ☐ N Mental Disorder
☐ Y ☐ N MRSA
☐ Y ☐ N Nervous System Disorder
☐ Y ☐ N ODD (Oppositional Defiant Disorder)
☐ Y ☐ N OCD (Obsessive Compulsive Disorder)
☐ Y ☐ N Osteoporosis
☐ Y ☐ N Pain in Jaw Joints
☐ Y ☐ N Parathyroid Disease
☐ Y ☐ N Parkinson's disease
☐ Y ☐ N Psychiatric Care
☐ Y ☐ N Renal Dialysis
☐ Y ☐ N Rheumatic Fever
☐ Y ☐ N Sinus Trouble
☐ Y ☐ N Smoker/Vaping
☐ Y ☐ N Speech Disorder
☐ Y ☐ N STD/ Venereal Disease
☐ Y ☐ N Stroke
☐ Y ☐ N Swelling of Limbs
☐ Y ☐ N Thyroid: Type _____
☐ Y ☐ N Tuberculosis
☐ Y ☐ N Tumors/Growths

Do you take an antibiotic prior to your dental appointments? ☐ Y ☐ N

Are you on blood thinners? ☐ Y ☐ N

WOMEN: Are you pregnant? ☐ Y ☐ N
Are you nursing? ☐ Y ☐ N

Have you ever taken a bisphosphonate medication by mouth or by IV? (Examples of this type of medication may include but are not limited to: Fosamax, Boniva, Aredia, Zometa, and Actonel) ☐ Y ☐ N Please explain:_____

Have you experienced any other medical conditions not listed above? ☐ Y ☐N Please list: _____

Are you presently under the care of a physician? ☐ Y ☐ N Physician's Name: _____Reason for care _____

Have you ever been hospitalized? ☐ Y ☐ N Please explain: _____

ALLERGIES: Are you allergic to any of the following?

☐ Y ☐ N Amoxicillin
☐ Y ☐ N Aspirin
☐ Y ☐ N Clindamycin
☐ Y ☐ N Codeine
☐ Y ☐ N Dental Anesthetic
☐ Y ☐ N Eggs
☐ Y ☐ N Erythromycin
☐ Y ☐ N Latex
☐ Y ☐ N Penicillin
☐ Y ☐ N Red Dye
☐ Y ☐ N Sulfur
☐ Y ☐ N Tylenol/Acetaminophen

Are you allergic to any other medications or foods that are not listed above? _____

DENTAL HISTORY:

Have you ever had a problem associated with previous dental work? ☐ Y ☐ N Please explain: _____

Name of your previous dentist: _____ Date of your last dental visit: _____

☐ Y ☐ N Do you brush your teeth daily?
☐ Y ☐ N Do you use dental floss?
☐ Y ☐ N Do you bite your nails?
☐ Y ☐ N Do you grind or clench your teeth?
☐ Y ☐ N Do your gums bleed while brushing or flossing your teeth?
☐ Y ☐ N Do you avoid brushing areas of your mouth due to pain?
☐ Y ☐ N Are you a mouth breather?
☐ Y ☐ N Have you had a facial or jaw injury?

MEDICATIONS: Please list all the medications, vitamins and supplements you are currently taking. If you have a list prepared please give this to the receptionist so it can be scanned into your chart.

Medication and Dose	*How much do you take and when?*	*What do you take it for?*	*Date started*

If there any information you feel we should know regarding your dental treatment, please let us know. _____

_____

By signing below you are agreeing the information above is accurate and complete to the best of your knowledge and you have provided Shallotte Family Dentistry with all the information needed to insure you have the most proper and safest care possible. With your signature you agree to contact our office if any major medical conditions occur including changes to your medications. You will be asked to update this form completely two years from the date below.

Patient Signature: _____ **Date**_____